STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
P.O Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer

APPLICATION FOR NURSE SUPPORT GROUP FACILITATOR/CO-FACILITATOR

Please print or type:

Name:		**RN License Number:**
Address:		
City:	**State:**	**Zip:**
Employer: **Work Phone:**		**Home Phone:**
Phone Number to be Given to the Public:		
E-Mail Address:		**Fax Number:**
I will be the:	***❑ Facilitator***	***❑ Co-Facilitator***
City where the nurse support group meeting will be held:		
Name of the nurse support group (if any):		

Please answer the following questions related to your qualifications:

1. ***Do your possess a current, unrestricted registered nurse license with no current or pending disciplinary action?*** ❑ *Yes* ❑ *No*

   Expiration date: _____

2. ***Have you been employed in the field of chemical dependency for at least one (1) year within the last three (3) years?*** ❑ *Yes* ❑ *No*

   If yes, complete:
   Employer: _____
   Job title: _____
   Dates of employment: _____
   Job description: _____
   _____
   _____

3. ***Have you completed (2) semester units, or three (3) quarter units or, thirty (30) hours of education or continuing education in the area of chemical dependency?*** ❑ *Yes* ❑ *No*

   If yes, indicate:
   Course titles: _____ ***Dates:*** _____
   _____ _____
   _____

4. ***Do you possess certification in the area of chemical dependency or are you eligible for certification?*** ❑ *Yes* ❑ *No*

If yes, indicate:

Certificate number: _____

Certifying organization: _____

Date issued: _____

Date eligible: _____

5. ***Do you have a minimum of six (6) month's experience facilitating a group?*** ❑ *Yes* ❑ *No*

If yes, please describe your experience: _____

_____

_____

_____

_____

Are you in recovery? ❑ *Yes* ❑ *No*

If yes, indicate number of years in recovery: _____ *years*

Please answer the following questions related to group meetings, if known:

1) ***If you are applying to become a co-facilitator, what is the Facilitator's name?*** _____

2) ***Address where the group will be meeting:*** _____

3) ***How many times a week will the group meet?*** _____

4) ***What day(s) of the week will the group meet?*** _____

5) ***What time will the group meet?*** _____

6) ***Will there be a fee for participation in the group? If yes, what will it be?*** _____

7) ***Will you waive the fee if participant cannot afford to pay?*** _____

8) ***What will be the maximum number of participants in the group?*** _____

9) ***Will you allow nurses who are <u>not</u> in Diversion to participate in the group?*** _____

10) ***Will you report relapses and attendance to the Diversion Program Contractor?*** _____

11) ***Will you provide input on participants when requested to do so by the Diversion Program Contractor?*** _____

(IF YOUR GROUP HAS ANY WRITTEN POLICIES REGARDING CONFIDENTIALITY, PURPOSE, RELAPSE, ATTENDANCE, ETC., PLEASE ENCLOSE THEM WITH YOUR APPLICATION.)

Please give a brief description of your beliefs relative to the role of nurse support groups in the recovery/rehabilitation of the impaired nurse:

I HAVE READ AND ACKNOWLEDGED THE BOARD OF REGISTERED NURSING'S POLICY ON THE ROLE OF NURSE SUPPORT GROUPS. I AGREE TO ABIDE BY THESE STIPULATIONS. I ALSO UNDERSTAND IF THE BOARD DETERMINES I AM NOT ABIDING BY THESE STIPULATIONS, MY APPROVAL AS A FACILITATOR/CO-FACILITATOR MAY BE RESCINDED.

_____ _____

Signature ***Date***